STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155446	A. BUILDING 00 B. WING	12/21/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVINGTON MANOR HEALTH AND REHABILITATION CENTER	5700 WILKIE DR FORT WAYNE, IN 46804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for investigation of Complaint IN00101272. Complaint IN00101272-Substantiated, Federal/State deficiencies related to the allegations are cited at F 157, F 282, F 314 and F 309. Survey dates: December 19, 20, and 21, 2011 Facility number: 000476 Provider number: 155446 AIM number: 100290870 Survey team: Diane Nilson, RN, TC Carol Miller, RN Census Bed type: SNF/NF: 134 Total: 134 Census payor type: Medicare: 11 Medicaid: 84 Other: 39 Total: 134 Sample: 3	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed 12/28/11 Cathy Emswiller RN			

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F0157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on interviews and record reviews, the facility failed to ensure the Physician was notified promptly when the residents had a change in condition resulting in having to have surgery (Resident C) and	F0157	1. The MD was notified of change of condition on 11/24/11 for resident C. Resident D no longer resides in the facility. 2. All residents were reviewed for changes in skin conditions with	01/20/2012

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	Resident D developed a 2nd pressure ulcer without physician notification. This deficiency affected 2 resident, Residents C and D, in a sample of 3. Findings include: 1. The clinical record of Resident C was reviewed on 12/19/11 at 1:45 p.m. and indicated the resident was admitted to the facility on 11/1/11, with diagnoses including, but not limited to, diabetes, and history of necrotizing fascitis of the scrotum. Review of a Change of Condition Skin Sheet, dated 11/21/11 at 11:00 p.m., indicated the following: "Res (resident) complained of toe bleeding through sock found 4 diabetic ulcers upon inspection 3 on 2nd (second) toe of res (right) foot, et (and) 1 of his 3rd (third) toe. slight amount of blood draining from OA (open area) on 2nd toe's ulcer, near toenail. Skin under toe is very pale. (No) c/o (complaints) pain. Wrapped (with) dressing et (and) contacted Dr. (Physician's name). Prescribed doxycycline (antibiotic) po (by mouth) BID (two times a day) x (times) 2 weeks, CBC (Complete Blood Count laboratory test) PT/PTT (Protime and Prothrombin Time laboratory test) et appt		MD notification as appropriate. 3. Licensed nurses will be inserviced on reporting changes of condition to the MD timely. UM/designee will monitor compliance 5 x weekly through the change of condition audit. Patterns of non-compliance will be addressed through progressive discipline. 4. Results of audits will be forwarded to QA&A monthly times 3 months for tracking and trending and quarterly thereafter	

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	(appointment) (with) wound clinic. Res aware...." A narrative nursing note, dated 11/22/11 at 2:00 p.m., indicated the dressing was changed to the 2nd and 3rd toes, the 2nd toe was swollen, bright red, and warm. The nurse's note also indicated there was 100% black area to the tip and bottom of the 2nd toe, and a small area to the top of the toe, with a moderate amount of drainage to both toes. Nursing notes, dated on 11/23/11 indicated the dressing to the toes was clean, dry, and intact, and the antibiotic was being given. There was no documentation the physician was notified regarding the black areas on the toes, until 11/24/11 at 6:30 p.m. A nursing note, dated 11/24/11 at 6:30 p.m., indicated the antibiotic treatment continued for the diabetic ulcers on the right 2nd and 3rd toes, and "ordered xeroform." There was no documentation in the note that the physician was made aware of the black toes. However, a physician's order, dated 11/24/11, indicated xeroform dressing to the right 2nd and 3rd toes twice a day. A nursing note, dated 11/25/11 at 10:00			

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	a.m., indicated the dressing was changed to the 2nd and 3rd right toes, the diabetic ulcers continued to the 2nd and 3rd superior toes, the 2nd digit had an open area on the inferior toe, and the drainage was purulent with a foul odor. The note indicated the 2nd digit inferior open area was black in color with surrounding skin pink and peeling, the 2nd and 3rd superior open area's wound beds were yellow/red, and the surrounding skin peeling and pink. A nursing note, dated 11/27/11 at 1:00 a.m., indicated the resident continued on an antibiotic for infection to the right toes, there was no odor noted, but purulent drainage was noted. A narrative nursing note, on the back of the skilled documentation flow sheet, and dated 11/27/11 at 11:30 p.m., indicated the resident ambulated per self using a walker, and was independent with activities of daily living. The note indicated there was a purulent, foul smelling drainage noted, and a black area to the 3rd toe, and open area to the 2nd toe. A non pressure skin condition report, dated 11/28/11, indicated the resident had necrotizing fascitis to bilateral feet.			

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	A nursing note, dated 11/28/11 (no time) indicated the resident had necrotizing fascitis to bilateral feet, the right foot was pale with purple discoloration and streaking noted, odor noted, the left foot was pale with purple discoloration, streaking present, and an odor. The resident had no complaints of pain, the physician was notified and the resident sent to the emergency room for evaluation. Review of an acute hospital transfer record, dated 11/28/11, indicated the resident was transferred to the hospital at 10:30 a.m. on 11/28/11. A nursing note, dated 12/5/11, indicated the resident was hospitalized. A history and physical, dated 11/28/11, from the local hospital, indicated the resident had diagnoses including, but not limited to: type 2 diabetes, anemia, hypertension, history of necrotizing fascitis left thigh, and Fournier's gangrene. The history and physical indicated the resident was transferred from the nursing home with cellulitis and possible osteomylitis. The physical exam indicated bilateral second digit foot gangrene. Xray of the right foot showed suspicious for only findings for 2nd distal phalanx,			

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	could be related to osteomylitis and healing fracture of the base of the 1st phalanx of the left foot showed fracture of the head of the 2nd phalanx. Also right foot 2nd digit showed findings suggestive of osteomylitis. A physician progress note, dated 12/7/11, indicated the resident was diagnosed with 2nd toe amputation, osteomylitis, peripheral arterial disease, and diabetes. The Director of Nursing Services (DNS), was interviewed on 12/20/11 at 9:05 a.m., and indicated the physician was notified regarding the condition of the toes on 11/24/11, and a new order was received for xeroform dressing. The facility policy received by the DNS on 12/20/11 at 10:00 a.m., Managing Change of Condition updated 10/2011 indicated "...If the change in condition does not appear life-threatening, the following steps may be followed:...2. Notify physician of assessment findings...." Resident C was interviewed, at 11:00 a.m. on 12/21/11, and indicated he noticed a scab on his toes and the toes were bleeding, so he reported this to the staff. He indicated he had to have 2 of his toes ambulated after this.			

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	The DNS was interviewed, on 12/21/11 at 2:15 p.m., and indicated Resident C did not have necrotizing fascitis of his bilateral feet. She indicated the wound nurse had documented this diagnosis, but the resident was diagnosed as having osteomylitis, not necrotizing fascitis 2. The clinical record of Resident D was reviewed on 12/19/11 at 10:00 a.m., and indicated the resident was readmitted to the facility on 10/20/11, with diagnoses including, but not limited to, diabetes, chronic kidney disease and coronary artery disease. The initial admission assessment, dated 10/20/11, indicated the resident had a slight rash in the abdominal folds, a bruise to the left upper/inner arm, 3+ pitting edema to the bilateral lower extremities, left anticubital bruising, and a left hip replacement incision. A Braden Scale assessment for predicting pressure sore risk was completed on 10/27, 11/3, and 11/10/11, and indicated the resident was not at risk for pressure sores. The treatment sheet for October, 2011, indicated weekly skin assessments were			

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	completed on admission and again on 10/27/11. Treatment sheets for November, 2011, indicated weekly skin assessments were completed. A nursing note, dated 10/30/11 at 12 noon, indicated the physician was notified due to the resident having 3+edema , and new orders were left for Bumex to be given daily, and lab ordered for 11/1/11. The resident also indicated she just felt bad. A nursing note, dated 10/31/11 at 10:50 a.m., indicated, "dark purple dti (deep tissue injury) noted to l (left) foot, lateral arch area. Dry calloused skin surrounding. Res (resident) c/o(complained of) mild pain sensation upon exam or pressure c (with) foot weight bearing. Edemas 3+ pitting continues bilat (bilateral) LE (lower extremities). " The Pressure Ulcer Evaluation Form, dated 10/30/11, indicated the resident had a deep tissue injury on the left foot, which measured 3 centimeters(cm) in length and 1.5 cm in width with no drainage. A change of condition report, dated 10/30/11, indicated the physician was contacted on 10/30/11 at 12 noon, regarding the new area, but left no new orders.			

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	The Pressure Evaluation Form indicated a deep tissue injury is defined as "...Purple or maroon localized area of discolored intact skin or blood- filled blister due to damage of underlying soft tissue from pressure and/or sheer...." A pressure ulcer evaluation form, dated 10/31/11, indicated an unstageable area to the left foot arch, measuring 1.2 cm by 2.5 cm, which was 100 percent eschar, and pink surrounding skin with swelling. Physician orders, dated 11/1/11, indicated cover the left lateral foot arch with a dry abdominal pad and fix with loose kerlix, change daily and as needed for loosening/soilage. Also a venous doppler study was ordered to the bilateral lower extremities, for swelling and pain to rule out deep vein thrombosis. Another physician order, dated 11/1/11, indicated bilateral extremity compression wraps with lymphatic massage was ordered due to edema. A bilateral lower extremity venous ultrasound test, dated 11/2/11, indicated no evidence of deep vein thrombosis involving the lower extremities bilaterally. A pressure ulcer evaluation, dated 11/7/11, indicated the area was			

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	unstageable, 100 percent eschar, and measured 1.1 cm by 3.0 cm. An occupational therapy daily treatment note, dated 11/16/11, indicated resident labs were drawn on 11/15/11, and the therapist was withholding the compression wraps due to the abnormal lab results. A physical therapy progress report, dated 11/18/11, indicated the open area to the left foot was improving, but now noted a small pressure area laterally to the right foot, and nursing was notified. A narrative nursing note, dated 11/18/11, at 11:15 a.m., indicated a new wound sheet was completed for a small, dry, deep tissue injury to the lateral side of the right foot, measuring 2 cm by 2 cm. A pressure ulcer evaluation form, dated 11/18/11, indicated there was a deep tissue injury to the right foot, lateral side, measuring 2 cm by 2 cm, no odors, no drainage, epithelialization, hard/scarred wound edges, and pink surrounding skin. A pressure ulcer evaluation form, dated 11/21/11, indicated the area on the right foot was unstageable, measured 0.5 by 0.8 cm, no odor or drainage, 100 percent eschar, wound edges defined, and the surrounding skin was pink.			

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	A pressure ulcer evaluation, dated 12/12/11, indicated the area was healed to the right foot. On 11/22/11 the resident was transferred to the hospital for a scheduled blood transfusion. A pressure ulcer evaluation, dated 12/19/11, indicated the area located on the left foot arch measured length was 0.8 centimeters (cm) and 1.8 cm. On 12/20/11 at 12:15 p.m. the LPN Wound Nurse was interviewed in regard to the cause of the pressure ulcers and she indicated she thought the pressure ulcers developed due to the resident had cellulitis and edema. On 12/20/11 at 12:45 p.m. the Certified Occupational Therapy Assistant (COTA) was interviewed in regard to the compression wraps and indicted the resident wore the compression wraps for 23 hours a day 7 days a week. The COTA further indicated she applied the wraps through the week and Nursing applied the wraps on the week-ends and both nursing and COTA were responsible for assessing the residents bilateral legs when the wraps were removed for 1 hour a day.			

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	On 12/20/11 at 4:55 p.m. the Director Nursing Service (DNS) was interviewed in regard to the resident's pressure ulcer and she indicated the resident only wore shoes in therapy after the first pressure ulcer developed. The DNS further indicated the resident had a special pressure reduction mattress with a "heel slope" On 12/21/11 at 10:45 a.m. an observation of the resident's pressure area with RN #3 was obtained to the left foot arch and the wound bed was pink and surrounding tissue were pink and slightly swollen with a scant amount of serosanguineous drainage on the old dressing. This federal tag relates to complaint IN00101272 3.1-5(a)(2)			

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F0282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on interviews and record reviews, the facility failed to ensure the resident's care plans were followed in regard notification of the Physician when Resident C, who had a change of condition resulting in having to have surgery and failed to ensure the Registered Dietician was notified and a reassessment of the resident's needs was completed (Resident B). This deficiency affected 2 of 3 residents whose care plans were not followed. Findings include: 1. The clinical record of Resident C was reviewed on 12/19/11, at 1:45 p.m. and indicated the resident was admitted to the facility on 11/1/11, with diagnoses including, but not limited to, diabetes, and history of necrotizing fascitis of the scrotum. The Minimum Data Set (MDS) Assessment, dated 11/11/11, indicated the resident scored 15/15 on the Brief Interview for Mental Status (BIM), and required limited assistance of one person	F0282	1. The MD was notified of the change of condition on 11/24/11 for resident C. Resident B no longer resides in the facility.2. All residents were reviewed for changes in skin conditions with MD notification as appropriate. As stated in the 2567, an audit was completed on 12/14 and 12/15/11 of the dietary progress notes and all progress notes have since been updated. 3. Licensed nurses will be inserviced on completing weekly skin assessments timely and notifying the MD of changes of conditions. UM/designee will monitor compliance 5 x weekly through the change of condition audit. Patterns of non-compliance will be addressed through progressive discipline. The Dietary Manager has been inserviced on completing progress notes timely. ED/designee will monitor through random audits of 5 residents 2 times per week for 1month, followed by 5 residents weekly for 2 months and 5 times a month for 3 months therafter. 4. Results of audits will be forwarded to QA&A monthly times 3 months for tracking and trending and quarterly thereafter.Addendum	01/20/2012

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	for dressing, toilet use, personal hygiene, and bathing. Review of the Nursing Admission Assessment, dated 11/1/11, indicated a skin graft to the right thigh, measuring 25 centimeters (cm) by 18 cm., and a skin graft to the penis. There were no other skin conditions identified on the assessment. Care plans were reviewed on 12/19/11. A skin integrity care plan, dated 11/7/11, indicated a potential for impaired skin integrity related to recent surgery, with problems related to impaired mobility and Diabetes Mellitus. Interventions for this problem included, but were not limited to: notify the physician promptly of skin breakdown; Review of the treatment sheet for November, 2011, indicated weekly skin assessments were completed on 11/2, 11/9, 11/17, and 11/24/11. Review of a Change of Condition Skin Sheet, dated 11/21/11 at 11:00 p.m.,indicated the following: "Res (resident) complained of toe bleeding through sock found 4 diabetic ulcers upon inspection 3 on 2nd (second)		A dietician communication form has been placed at the nurses stations for completion. The dietician then reviews these forms for any required follow up on each visit weekly. ED/Designee will review the follow up during previously stated random audits, ED/designee will monitor through random audits of 5 residents 2 times per week for 1 month, followed by 5 residents weekly for 2 months and 5 times a month for 3 months thereafter.	

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	toe of res (right) foot, et (and) 1 of his 3rd (third) toe. slight amount of blood draining from OA (open area) on 2nd toe's ulcer, near toenail. Skin under toe is very pale. (No) c/o (complaints) pain. Wrapped (with) dressing et (and) contacted Dr. (Physician's name). Prescribed doxycycline (antibiotic) po (by mouth) BID (two times a day) x (times) 2 weeks, CBC (Complete Blood Count laboratory test) PT/PTT (Protime and Prothrombin Time laboratory test) et appt (appointment) (with) wound clinic. Res aware...." A narrative nursing note, dated 11/22/11 at 2:00 p.m., indicated the dressing was changed to the 2nd and 3rd toes, the 2nd toe was swollen, bright red, and warm. The nurse's note also indicated there was 100% black area to the tip and bottom of the 2nd toe, and a small area to the top of the toe, with a moderate amount of drainage to both toes. Nursing notes, dated on 11/23/11 indicated the dressing to the toes was clean, dry, and intact, and the antibiotic was being given. There was no documentation the physician was notified regarding the black areas on the toes, until 11/24/11, at 6:30 p.m. A nursing note, dated 11/24/11, at			

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	6:30 p.m., indicated the antibiotic treatment continued for the diabetic ulcers on the right 2nd and 3rd toes, and "ordered xeroform." There was no documentation in the note that the physician was made aware of the black toes. However, a physician's order, dated 11/24/11, indicated xeroform dressing to the right 2nd and 3rd toes twice a day. A nursing note, dated 11/25/11, at 10:00 a.m., indicated the dressing was changed to the 2nd and 3rd right toes, the diabetic ulcers continued to the 2nd and 3rd superior toes, the 2nd digit had an open area on the inferior toe, and the drainage was purulent with a foul odor. The note indicated the 2nd digit inferior open area was black in color with surrounding skin pink and peeling, the 2nd and 3rd superior open area's wound beds were yellow/red, and the surrounding skin peeling and pink. A nursing note, dated 11/27/11 at 1:00 a.m., indicated the resident continued on an antibiotic for infection to the right toes, there was no odor noted, but purulent drainage was noted. A narrative nursing note, on the back of the skilled documentation flow sheet, and dated 11/27/11, at 11:30 p.m., indicated			

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	the resident ambulated per self using a walker, and was independent with activities of daily living. The note indicated there was a purulent, foul smelling drainage noted, and a black area to the 3rd toe, and open area to the 2nd toe. A non pressure skin condition report, dated 11/28/11, indicated the resident had necrotizing fascitis to bilateral feet. A nursing note, dated 11/28/11 (no time) indicated the resident had necrotizing fascitis to bilateral feet, the right foot was pale with purple discoloration and streaking noted, odor noted, the left foot was pale with purple discoloration, streaking present, and an odor. The resident had no complaints of pain, the physician was notified and the resident sent to the emergency room for evaluation. Review of an acute hospital transfer record, dated 11/28/11, indicated the resident was transferred to the hospital at 10:30 a.m. on 11/28/11. A nursing note, dated 12/5/11, indicated the resident was hospitalized. A history and physical, dated 11/28/11, from the local hospital, indicated the			

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	resident had diagnoses including, but not limited to: type 2 diabetes, anemia, hypertension, history of necrotizing fascitis left thigh, and Fournier's gangrene. The history and physical indicated the resident was transferred from the nursing home with cellulitis and possible osteomylitis. The physical exam indicated bilateral second digit foot gangrene. Xray of the right foot showed suspicious for only findings for 2nd distal phalanx, could be related to osteomylitis and healing fracture of the base of the 1st phalanx of the left foot showed fracture of the head of the 2nd phalanx. Also right foot 2nd digit showed findings suggestive of osteomylitis. A physician progress note, dated 12/7/11, indicated the resident was diagnosed with 2nd toe amputation, osteomylitis, peripheral arterial disease, and diabetes. The Director of Nursing Services (DNS), was interviewed on 12/20/11, at 9:05 a.m., and indicated the physician was notified regarding the condition of the toes on 11/24/11, and a new order was received for xeroform dressing. Resident C was interviewed, at 11:00 a.m., on 12/21/11, and indicated staff assisted him with washing his back and			

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	hair in the shower. He indicated he noticed a scab on his toes and the toes were bleeding, so he reported this to the staff. He indicated he had to have 2 of his toes ambulated after this. The DNS was interviewed, on 12/21/11 at 2:15 p.m., and indicated Resident C did not have necrotizing fascitis of his bilateral feet. She indicated the wound nurse had documented this diagnosis, but the resident was diagnosed as having osteomylitis, not necrotizing fascitis 2. The closed record for Resident B, was reviewed at 10:55 a.m., on 12/19/11. The resident was admitted to the facility on 11/7/11, with diagnoses, including, but not limited to: Quadriplegia, recurrent Urinary Tract Infections (UTIs), Hypokalemia, Gross Hematuria, Anemia, Sepsis, Urinary Retention, Urolithiasis, and History of Sacral decubitus ulcer. Review of the Medication Administration Record for December, 2011, also indicated blood sugars were checked before meals and at bedtime, and the resident was on sliding scale insulin coverage. Review of a History and Physical, dated 8/20/11, from a local hospital (hospital 1), indicated the resident had a past			

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	medical history of Quadriplegia after a neck injury, Status post supra pubic catheter in 1980, Sacral decubitus ulcer, Recurrent UTIs, and Debridement of a sacral decubitus in the past. Review of another History and Physical, from another local hospital (hospital 2), and dated 10/6/11, indicated the resident was admitted to hospital 1 on 8/19/11 because of hematuria and urosepsis, developed perforation and had septic shock, went into respiratory failure from the sepsis, and had a tracheostomy. The resident was transferred to hospital 2 on 10/3/11, for continued antibiotics and recuperation, had not been able to eat and was fed through a Gastrostomy tube. A nursing admission assessment, dated 11/7/11, indicated the resident had a history of pressure ulcers, and was assessed to have a scar on the coccyx, and a small scabbed area on the right toe, but no other skin conditions. The initial skin interventions listed included pressure reducing mattress, repositioning program, and incontinence management. The assessment also revealed the resident had a catheter in place and a Gastrostomy tube. A nursing note, dated 11/7/11 at 4:45 p.m., indicated the resident was admitted			

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	with a tracheostomy, peg tube and was to get Pivot 50 cubic centimeters (cc) an hour from 8:00 p.m., to 6:00 a.m., had a catheter, and was on a mechanical soft diet. A nutrition screening and assessment, dated 11/11/11, indicated the resident was receiving a supplement, Pivot, at 50 cc hour at night, and skin was intact. A Braden scale assessment, for predicting pressure sore risk, indicated assessments were completed on 11/7/11, 11/21/11, and 11/28/11, and indicated the resident scored "9" with a total score of 12 or less representing a high risk for pressure sore. A pressure ulcer evaluation record, dated 11/26/11, indicated the resident developed a stage 2 pressure ulcer on the right buttock, measuring 2.0 centimeters (cm) by 2.0 cm, no odor, scant serous drainage, non-granulating, and intact surrounding skin. A reassessment, completed on 11/28/11, indicated the same assessment information as was documented on 11/26/11. A nursing note, dated 11/29/11, indicated the resident was started on an antibiotic Intravenously, for 10 days, due			

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	to an abnormal urinalysis, but there was no further documentation in the nursing notes regarding the pressure ulcer on the resident's buttocks, until a nursing note, dated on 12/3/11, at 9:00 a.m., indicated the sacral wound was 50 percent slough and granulation tissue with a medium amount to bloody drainage, and had a slight odor, no signs or symptoms of infection. A nursing note, dated 12/4/11, at 9:00 a.m., indicated the resident continued to have the wound on the sacrum dressing applied as ordered, and the wound was 50 percent slough and granulation tissue, and the wound was actively bleeding and continued to have a slight odor, with wound edges attached, and no signs or symptoms of infection. Review of the ulcer evaluation record, dated 12/4/11, indicated the wound measured 7.0 cm. by 6.0 cm, had an odor, with moderate sanguineous drainage, 50 percent slough, pink surrounding skin, and was unstageable. A physician's order, dated 12/4/11, indicated the Vasolex to the buttocks was to be discontinued, and a new order to cleanse the sacrum ulcer and apply Exuderm odorshield sacrum patch on 12/4/11, and change on Monday, Wednesday, and Fridays. The orders also			

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	indicated Vitamin C 500 milligrams twice a day for 30 days, and Zinc 220 milligrams, every day for 30 days, to promote wound healing, and a referral to the Wound Clinic. Another physician order, dated 12/4/11, indicated the Pivot tube feeding was discontinued, and the resident was to be started on Diabetasource. A change in condition report, dated 12/4/11, at 11:00 p.m., indicated the resident was sent to the emergency room due to inability to get adequate air exchange through his tracheostomy. A nursing note, dated 12/5/11, at 2:00 a.m., indicated the resident had returned from the hospital, with a new tracheostomy. A nursing note, dated 12/7/11, at 4:00 p.m., indicated the resident was informed the physician had recommended treatment at the wound clinic. The note indicated the resident refused the appointment due to problems with the area on his buttocks opening from time to time. The resident indicated, "he knew his body and knew what the doctor will say, so he would rather tx (treat) like he has in the past, and will follow up c (with) wound clinic if needed after he does what the doctor has ordered in the past."			

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	Care plans, dated 11/11/11, indicated a potential for impaired skin integrity related to Quadriplegia, impaired mobility, incontinence, pain, and history of breakdown. Interventions included, but not limited to: pressure reducing mattress to bed, pressure reducing cushion to wheelchair, observe skin integrity during am/pm care, refer to RD (registered dietician) as needed to evaluate diet/needs, evaluate skin weekly, and low loss air mattress. A nutrition screening and assessment, dated 11/11/11, indicated the skin was intact. The only other nutritional progress note, dated 12/2/11, was documented by the dietary manager, and indicated the resident was on a mechanical soft diet, current weight was 210 pounds, and Pivot was used in the tube feeding. There was no dietary notes or interventions on the care plan regarding the development of the pressure sore. A discharge instruction sheet, dated 12/9/11, indicated the resident was discharged to home with home health care, and friends were to provide 24 hour care. A skin Condition report, dated 12/9/11, on discharge, indicated the resident had sacral wounds with buttocks excoriation,			

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	stage 2, on the coccyx/sacrum. The DNS was interviewed, at 2:35 p.m., on 12/19/11, and indicated the resident did not have any open areas when he was admitted, but had a history of pressure sores. She indicated because the resident had a history of pressure sores, he was placed on a low loss alternating air mattress, and pressure cushion placed in his wheelchair, on admission. The DNS was interviewed on 12/20/11, at 9:03 a.m., and indicated there were no additional dietary progress notes documented, and the Dietary Manager was no longer employed at the facility and had resigned, with her last day worked on 12/7/11. The DNS indicated she had done an audit of the dietary progress notes on 12/14 and 12/15/11, and found the dietary notes to be out of compliance. She indicated the CNAs documented anything unusual when showers were given to the residents, 2 times weekly, and also when dressing the residents,and then reported to the nurses if anything unusual was found. She indicated the nurses did skin assessments on every resident on a weekly basis, not just on residents at risk for pressure sores. Review of the "Best Practice Skin			

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	Integrity Process" policy, provided by the Director of Nursing Services (DNS), at 10:00 a.m., on 12/20/11, indicated the following: Dietary support would include additional nutritional supplement or fortified diet according to the Registered Dietician's recommendations; Revise care plan as appropriate. This federal tags relates to complaint IN00101272. 3.1-35(g)(2)			

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F0309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on interviews and record reviews, the facility failed to ensure care and services were provided to prevent the development of diabetic ulcers and to promptly notify the Physician with a change in condition of the resident's toes that resulted in osteomylitis of the bone, and surgical amputation of the to the second toe of the right foot. This deficiency affected 1 resident, Resident C, in a sample of 3. Findings include: The clinical record of Resident C was reviewed on 12/19/11, at 1:45 p.m. and indicated the resident was admitted to the facility on 11/1/11, with diagnoses including, but not limited to, diabetes, and history of necrotizing fascitis of the scrotum. The Minimum Data Set(MDS) Assessment, dated 11/11/11, indicated the resident scored 15/15 on the Brief Interview for Mental Status (BIM), and	F0309	1. The MD was notified of change of condition on 11/24/11 for resident C.2. All residents were reviewed for changes in skin conditions with MD notification as appropriate.3. Licensed nurses will be inserviced on reporting changes of condition to the MD timely. UM/designee will monitor compliance 5 x weekly through the change of condition audit. Patterns of non-compliance will be addressed through progressive discipline.4. Results of audits will be forwarded to QA&A monthly times 3 months for tracking and trending and quarterly thereafter.Addendum A dietician communication form has been placed at the nurses stations for completion. The dietician then reviews these forms for any required follow up on each visit weekly. ED/Designee will review the follow up during previously stated random audits, ED/designee will monitor through random audits of 5 residents 2 times per week for 1 month, followed by 5 residents weekly for 2 months and 5 times a month for 3 months thereafter.	01/20/2012

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	required limited assistance of one person for dressing, toilet use, personal hygiene, and bathing. Review of the Nursing Admission Assessment, dated 11/1/11, indicated a skin graft to the right thigh, measuring 25 centimeters (cm) by 18 cm., and a skin graft to the penis. There were no other skin conditions identified on the assessment. Care plans were reviewed on 12/19/11. A skin integrity care plan, dated 11/7/11, indicated a potential for impaired skin integrity related to recent surgery, with problems related to impaired mobility and Diabetes Mellitus. Interventions for this problem included, but were not limited to: observe skin integrity during morning and evening care; notify the physician promptly of skin breakdown; evaluate skin weekly. Another care plan, dated 11/1/11, for self care deficit indicated the resident required limited assistance for bed mobility, transfers, ambulation, dressing, personal hygiene, bathing, and toilet use. Interventions for this problem included, but not limited to: one person physical assist for bed mobility, transfers, ambulation,		C.N.A.'s have been inserviced on reporting changes in skin color or condition to the nurse. The C.N.A documentation system prompts staff during showers/bed baths to report to nurse any warm, discolored, or open areas. All residents receive at a minimum three observations weekly regarding the condition of their skin. The license nurse documents the condition of each residents skin weekly. Additionally there are observations of the residents skin during their, at a minimum, 2 scheduled shower times weekly. Unit managers will validate weekly skin assessment accuracy through random audits of a total of 5 observations weekly.	

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	locomotion, dressing, toilet use, and bathing. Review of the treatment sheet for November, 2011, indicated weekly skin assessments were completed on 11/2, 11/9, 11/17, and 11/24/11. Review of a Change of Condition Skin Sheet, dated 11/21/11 at 11:00 p.m.,indicated the following: "Res (resident) complained of toe bleeding through sock found 4 diabetic ulcers upon inspection 3 on 2nd (second) toe of res (right) foot, et (and) 1 of his 3rd (third) toe. slight amount of blood draining from OA (open area) on 2nd toe's ulcer, near toenail. Skin under toe is very pale. (No) c/o (complaints) pain. Wrapped (with) dressing et (and) contacted Dr. (Physician's name). Prescribed doxycycline (antibiotic) po (by mouth) BID (two times a day) x (times) 2 weeks, CBC (Complete Blood Count laboratory test) PT/PTT (Protime and Prothrombin Time laboratory test) et appt (appointment) (with) wound clinic. Res aware...." A narrative nursing note, dated 11/22/11 at 2:00 p.m., indicated the dressing was changed to the 2nd and 3rd toes, the 2nd toe was swollen, bright red, and warm.			

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	The nurse's note also indicated there was 100% black area to the tip and bottom of the 2nd toe, and a small area to the top of the toe, with a moderate amount of drainage to both toes. Nursing notes, dated on 11/23/11 indicated the dressing to the toes was clean, dry, and intact, and the antibiotic was being given. There was no documentation the physician was notified regarding the black areas on the toes, until 11/24/11, at 6:30 p.m. A nursing note, dated 11/24/11, at 6:30 p.m., indicated the antibiotic treatment continued for the diabetic ulcers on the right 2nd and 3rd toes, and "ordered xeroform." There was no documentation in the note that the physician was made aware of the black toes. However, a physician's order, dated 11/24/11, indicated xeroform dressing to the right 2nd and 3rd toes twice a day. A nursing note, dated 11/25/11, at 10:00 a.m., indicated the dressing was changed to the 2nd and 3rd right toes, the diabetic ulcers continued to the 2nd and 3rd superior toes, the 2nd digit had an open area on the inferior toe, and the drainage was purulent with a foul odor. The note indicated the 2nd digit inferior open area			

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	was black in color with surrounding skin pink and peeling, the 2nd and 3rd superior open area's wound beds were yellow/red, and the surrounding skin peeling and pink. A nursing note, dated 11/27/11 at 1:00 a.m., indicated the resident continued on an antibiotic for infection to the right toes, there was no odor noted, but purulent drainage was noted. A narrative nursing note, on the back of the skilled documentation flow sheet, and dated 11/27/11, at 11:30 p.m., indicated the resident ambulated per self using a walker, and was independent with activities of daily living. The note indicated there was a purulent, foul smelling drainage noted, and a black area to the 3rd toe, and open area to the 2nd toe. A non pressure skin condition report, dated 11/28/11, indicated the resident had necrotizing fascitis to bilateral feet. A nursing note, dated 11/28/11 (no time) indicated the resident had necrotizing fascitis to bilateral feet, the right foot was pale with purple discoloration and streaking noted, odor noted, the left foot was pale with purple discoloration, streaking present, and an odor. The			

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	resident had no complaints of pain, the physician was notified and the resident sent to the emergency room for evaluation. Review of an acute hospital transfer record, dated 11/28/11, indicated the resident was transferred to the hospital at 10:30 a.m. on 11/28/11. A nursing note, dated 12/5/11, indicated the resident was hospitalized. A history and physical, dated 11/28/11, from the local hospital, indicated the resident had diagnoses including, but not limited to: type 2 diabetes, anemia, hypertension, history of necrotizing fascitis left thigh, and Fournier's gangrene. The history and physical indicated the resident was transferred from the nursing home with cellulitis and possible osteomylitis. The physical exam indicated bilateral second digit foot gangrene. Xray of the right foot showed suspicious for only findings for 2nd distal phalanx, could be related to osteomylitis and healing fracture of the base of the 1st phalanx of the left foot showed fracture of the head of the 2nd phalanx. Also right foot 2nd digit showed findings suggestive of osteomylitis.			

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	A physician progress note, dated 12/7/11, indicated the resident was diagnosed with 2nd toe amputation, osteomylitis, peripheral arterial disease, and diabetes. The Director of Nursing Services (DNS), was interviewed on 12/20/11, at 9:05 a.m., and indicated the physician was notified regarding the condition of the toes on 11/24/11, and a new order was received for xeroform dressing. Resident C was interviewed, at 11:00 a.m., on 12/21/11, and indicated staff assisted him with washing his back and hair in the shower. He indicated he noticed a scab on his toes and the toes were bleeding, so he reported this to the staff. He indicated he had to have 2 of his toes ambulated after this. CNA # 1 was interviewed, at 12:03 p.m., on 12/21/11, and indicated she took care of Resident C on the day shift, but the evening shift did Resident C's showers. She indicated when she did showers on any residents, she always checked their skin and reported anything unusual to the nurse. She indicated the resident required a little assistance when he first came to the facility, but was pretty independent, and able to dress himself, and toilet himself.			

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	The DNS was interviewed, on 12/21/11 at 2:15 p.m., and indicated Resident C did not have necrotizing fascitis of his bilateral feet. She indicated the wound nurse had documented this diagnosis, but the resident was diagnosed as having osteomylitis, not necrotizing fascitis CNA # 2 was interviewed, on 12/21/11, at 2:30 p.m., and indicated she took care of Resident C on the evening shift, and showered him at least weekly. She indicated she washed his back and he was able to wash the rest of his body. She indicated she checked his skin with every shower, head to toe, and reported anything unusual to the nurse. This federal tags relates to complaint IN00101272. 3.1-37(a)			

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F0314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on observation, record reviews, and interviews, the facility failed to ensure to implement a skin condition sheet completed by the Licensed Nurse to assure assessments were complete, failed to ensure the Registered Dietician was notified and a reassessment of the resident's needs was completed to ensure adequate nutrition, resulting in an unstageable pressure ulcer 7 centimeters (cm) by 6 cm with bloody drainage, slight odor and 50% slough (Resident B). The facility failed to ensure Resident D did not develop 2 pressure ulcers one was a deep tissue injury on the left foot and one was an unstageable pressure on the right foot. This deficiency affected 2 residents who developed pressure ulcers in a sample of 3 (Resident B and D) Findings include:	F0314	1. Resident B and D no longer reside in the facility.2. All residents were reviewed for changes in skin conditions with MD notification as appropriate. As stated in the 2567, an audit was completed on 12/14 and 12/15/11 of the dietary progress notes and all progress notes have since been updated.3. Licensed nurses will be inserviced on completing weekly skin assessments timely and notifying the MD of changes of conditions. UM/designee will monitor compliance 5 x weekly through the change of condition audit. Patterns of non-compliance will be addressed through progressive discipline. The Dietary Manager has been inserviced on completing progress notes timely. ED/designee will monitor through random audits of 5 residents 2 times per week for 1month, followed by 5 residents weekly for 2 months and 5 times a month for 3 months therafter. 4. Results of	01/20/2012

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	1. The closed record for Resident B, was reviewed at 10:55 a.m., on 12/19/11. The resident was admitted to the facility on 11/7/11, with diagnoses, including, but not limited to: Quadriplegia, recurrent Urinary Tract Infections (UTIs), Hypokalemia, Gross Hematuria, Anemia, Sepsis, Urinary Retention, Urolithiasis, and History of Sacral decubitus ulcer. Review of the Medication Administration Record for December, 2011, also indicated blood sugars were checked before meals and at bedtime, and the resident was on sliding scale insulin coverage. Review of a History and Physical, dated 8/20/11, from a local hospital (hospital 1), indicated the resident had a past medical history of Quadriplegia after a neck injury, Status post supra pubic catheter in 1980, Sacral decubitus ulcer, Recurrent UTIs, and Debridement of a sacral decubitus in the past. Review of another History and Physical, from another local hospital (hospital 2), and dated 10/6/11, indicated the resident was admitted to hospital 1 on 8/19/11 because of hematuria and urosepsis, developed perforation and had septic shock, went into respiratory failure from the sepsis, and had a tracheostomy. The resident was transferred to hospital 2 on		audits will be forwarded to QA&A monthly time 3 months for tracking and trending and quarterly thereafter.Addendum C.N.A.'s have been inserviced on reporting changes in skin color or condition to the nurse. The C.N.A documentation system prompts staff during showers/bed baths to report to nurse any warm, discolored, or open areas. All residents receive at a minimum three observations weekly regarding the condition of their skin. The license nurse documents the condition of each residents skin weekly. Additionally there are observations of the residents skin during their, at a minimum, 2 scheduled shower times weekly. Unit managers will validate weekly skin assessment accuracy through random audits of a total of 5 observations weekly.	

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	10/3/11, for continued antibiotics and recuperation, had not been able to eat and was fed through a Gastrostomy tube. A nursing admission assessment, dated 11/7/11, indicated the resident had a history of pressure ulcers, and was assessed to have a scar on the coccyx, and a small scabbed area on the right toe, but no other skin conditions. The initial skin interventions listed included pressure reducing mattress, repositioning program, and incontinence management. The assessment also revealed the resident had a catheter in place and a Gastrostomy tube. A nursing note, dated 11/7/11 at 4:45 p.m., indicated the resident was admitted with a tracheostomy, peg tube and was to get Pivot 50 cubic centimeters (cc) an hour from 8:00 p.m., to 6:00 a.m., had a catheter, and was on a mechanical soft diet. A nutrition screening and assessment, dated 11/11/11, indicated the resident was receiving a supplement, Pivot, at 50 cc hour at night, and skin was intact. A Braden scale assessment, for predicting pressure sore risk, indicated assessments were completed on 11/7/11, 11/21/11, and 11/28/11, and indicated the resident scored "9" with a total score			

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	of 12 or less representing a high risk for pressure sore. A pressure ulcer evaluation record, dated 11/26/11, indicated the resident developed a stage 2 pressure ulcer on the right buttock, measuring 2.0 centimeters (cm) by 2.0 cm, no odor, scant serous drainage, non-granulating, and intact surrounding skin. A reassessment, completed on 11/28/11, indicated the same assessment information as was documented on 11/26/11. A nursing note, dated 11/29/11, indicated the resident was started on an antibiotic Intravenously, for 10 days, due to an abnormal urinalysis, but there was no further documentation in the nursing notes regarding the pressure ulcer on the resident's buttocks, until a nursing note, dated on 12/3/11, at 9:00 a.m., indicated the sacral wound was 50 percent slough and granulation tissue with a medium amount to bloody drainage, and had a slight odor, no signs or symptoms of infection. A nursing note, dated 12/4/11, at 9:00 a.m., indicated the resident continued to have the wound on the sacrum dressing applied as ordered, and the wound was 50 percent slough and granulation tissue,			

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	and the wound was actively bleeding and continued to have a slight odor, with wound edges attached, and no signs or symptoms of infection. Review of the ulcer evaluation record, dated 12/4/11, indicated the wound measured 7.0 cm. by 6.0 cm, had an odor, with moderate sanguineous drainage, 50 percent slough, pink surrounding skin, and was unstageable. A physician's order, dated 12/4/11, indicated the Vasolex to the buttocks was to be discontinued, and a new order to cleanse the sacrum ulcer and apply Exuderm odorshield sacrum patch on 12/4/11, and change on Monday, Wednesday, and Fridays. The orders also indicated Vitamin C 500 milligrams twice a day for 30 days, and Zinc 220 milligrams, every day for 30 days, to promote wound healing, and a referral to the Wound Clinic. Another physician order, dated 12/4/11, indicated the Pivot tube feeding was discontinued, and the resident was to be started on Diabetasource. A change in condition report, dated 12/4/11, at 11:00 p.m., indicated the resident was sent to the emergency room due to inability to get adequate air exchange through his tracheostomy.			

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	A nursing note, dated 12/5/11, at 2:00 a.m., indicated the resident had returned from the hospital, with a new tracheostomy. A nursing note, dated 12/7/11, at 4:00 p.m., indicated the resident was informed the physician had recommended treatment at the wound clinic. The note indicated the resident refused the appointment due to problems with the area on his buttocks opening from time to time. The resident indicated, "he knew his body and knew what the doctor will say, so he would rather tx (treat) like he has in the past, and will follow up c (with) wound clinic if needed after he does what the doctor has ordered in the past." Care plans, dated 11/11/11, indicated a potential for impaired skin integrity related to Quadriplegia, impaired mobility, incontinence, pain, and history of breakdown. Interventions included, but not limited to: pressure reducing mattress to bed, pressure reducing cushion to wheelchair, observe skin integrity during am/pm care, refer to RD (registered dietician) as needed to evaluate diet/needs, evaluate skin weekly, and low loss air mattress. Review of the treatment sheet for November, 2011, indicated weekly skin			

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	assessments were to be completed with a narrative. An admission assessment, was completed on 11/7/11, however, there were blanks under the marked off dates for 11/14/11, 11/21/11, and 11/28/11 on the treatment sheet. A nutrition screening and assessment, dated 11/11/11, indicated the skin was intact. The only other nutritional progress note, dated 12/2/11, was documented by the dietary manager, and indicated the resident was on a mechanical soft diet, current weight was 210 pounds, and Pivot was used in the tube feeding. There was no dietary notes or interventions on the care plan regarding the development of the pressure sore. A discharge instruction sheet, dated 12/9/11, indicated the resident was discharged to home with home health care, and friends were to provide 24 hour care. A skin Condition report, dated 12/9/11, on discharge, indicated the resident had sacral wounds with buttocks excoriation, stage 2, on the coccyx/sacrum. The DNS was interviewed, at 2:35 p.m., on 12/19/11, and indicated the resident did not have any open areas when he was admitted, but had a history of pressure			

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	sores. She indicated because the resident had a history of pressure sores, he was placed on a low loss alternating air mattress, and pressure cushion placed in his wheelchair, on admission. The Rehab Nurse Manager, was interviewed, on 12/19/11, at 2:49 p.m., and indicated the resident was "pretty compliant" was transferred using the hoyer lift, was in Physical, Occupational, and Speech therapies, and had a feeding tube for nutrition, but also ate food by mouth. She also indicated the resident was alert and oriented, and made his own health care decisions. The wound nurse was interviewed on 12/19/11, at 3:00 p.m., and indicated the resident had told her he had a history of a wound on his buttocks, that would close and re-open. She indicated the initial nursing assessment had identified a "scar" on the resident's coccyx area. She indicated the stage 2 pressure ulcer which developed on 11/26/11, was close to the coccyx area, and she did not see scars anywhere else on the resident. She indicated the nurses did weekly skin assessments on the residents, and once a skin condition was identified, she did weekly assessments and measured the wound. She indicated between her weekly assessments, the floor nurses did the			

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	treatments and assessed the wounds. The wound nurse indicated she did the assessment on 11/26/11 for the stage 2 pressure ulcer because she was on call that weekend, and then reassessed the area on 11/28/11, her routine day for doing the wound assessments. She indicated she was weekend supervisor on 12/4/11, and reassessed the wound which measured 7.0 cm by 6 cm, and was unstageable. She indicated this was the same wound which was identified as a stage 2 pressure ulcer on 11/26 and 11/28/11, but had now become a larger area. She indicated when she assessed the area on 12/4/11, it was 50 percent slough, so was unstageable. The wound nurse indicated she talked to the resident about going to the wound clinic to make sure he had the appointment available before he was discharged from the facility, but the resident refused because he indicated he had the same thing before and knew the physician would just "slap yellow stuff" on the wound and he would just have to sit and wait at the wound clinic. The wound nurse indicated the resident had a low loss air mattress in place, and she had even checked the inflation in the air mattress to make sure there were proper preventions in place. The DNS was interviewed at 4:00 p.m.,			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVINGTON MANOR HEALTH AND REHABILITATION CENTER	5700 WILKIE DR FORT WAYNE, IN 46804

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	on 12/19/11, and indicated the initial skin assessment for Resident B was completed on 11/7/11 when the resident was admitted, but none of the other weekly skin assessments had been completed. The DNS indicated a corporate nurse had visited on 11/28/11, and identified a concern that the weekly skin assessments on some of the residents had not been completed, and Resident B was one of the residents identified. The DNS indicated the facility policy to turn the resident every 2 hours was followed and a low loss alternating pressure mattress offloaded pressure every 10 minutes was used. The DNS was interviewed on 12/20/11, at 9:03 a.m., and indicated there were no additional dietary progress notes documented, and the Dietary Manager was no longer employed at the facility and had resigned, with her last day worked on 12/7/11. The DNS indicated she had done an audit of the dietary progress notes on 12/14 and 12/15/11, and found the dietary notes to be out of compliance. The DNS was interviewed at 10:45 a.m., on 12/20/11, and indicated the nurses documented on the Medicare skilled flow sheet on a daily basis, on the rehab unit, and even though there was not an area to document skin assessments, it would be			

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	expected the nurses would document anything unusual. She indicated the CNAs documented anything unusual when showers were given to the residents, 2 times weekly, and also when dressing the residents,and then reported to the nurses if anything unusual was found. She indicated the nurses did skin assessments on every resident on a weekly basis, not just on residents at risk for pressure sores. Review of the "Best Practice Skin Integrity Process" policy, provided by the Director of Nursing Services (DNS), at 10:00 a.m., on 12/20/11, indicated the following: Daily communication by CNA to licensed nurse utilizing a skin condition worksheet or comparable document; Documentation of the turning and repositioning at least every two (2) hours while in bed or in a chair; Assigned shower/bed bath schedule for residents will include utilization of skin condition worksheet by the CNA with licensed nurse co-signature; Weekly "head to toe" assessment of all residents by Licensed nurses with narrative documentation of findings; Dietary support would include additional nutritional supplement or fortified diet according to the Registered Dietician's recommendations;			

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	Revise care plan as appropriate. 2. The clinical record of Resident D was reviewed on 12/19/11, at 10:00 a.m., and indicated the resident was readmitted to the facility on 10/20/11, with diagnoses including, but not limited to, diabetes, chronic kidney disease and coronary artery disease. The initial admission assessment, dated 10/20/11, indicated the resident had a slight rash in the abdominal folds, a bruise to the left upper/inner arm, 3+ pitting edema to the bilateral lower extremities, left anticubital bruising, and a left hip replacement incision. A Braden Scale assessment for predicting pressure sore risk was completed on 10/27, 11/3, and 11/10/11, and indicated the resident was not at risk for pressure sores. The treatment sheet for October, 2011, indicated weekly skin assessments were completed on admission and again on 10/27/11. Treatment sheets for November, 2011, indicated weekly skin assessments were completed.			

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	A nursing note, dated 10/30/11, at 12 noon, indicated the physician was notified due to the resident having 3+edema , and new orders were left for Bumex to be given daily, and lab ordered for 11/1/11. The resident also indicated she just felt bad. A nursing note, dated 10/31/11, at 10:50 a.m., indicated, "dark purple dti (deep tissue injury) noted to l (left) foot, lateral arch area. Dry calloused skin surrounding. Res (resident) c/o(complained of) mild pain sensation upon exam or pressure c (with) foot weight bearing. Edemas 3+ pitting continues bilat (bilateral) LE (lower extremities). " The Pressure Ulcer Evaluation Form, dated 10/30/11, indicated the resident had a deep tissue injury on the left foot, which measured 3 centimeters(cm) in length and 1.5 cm in width with no drainage. A change of condition report, dated 10/30/11, indicated the physician was contacted on 10/30/11 at 12 noon, regarding the new area, but left no new orders. The Pressure Evaluation Form indicated a deep tissue injury is defined as "...Purple or maroon localized area of discolored intact skin or blood- filled blister due to damage of underlying soft tissue from pressure and/or sheer...."			

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	A pressure ulcer evaluation form, dated 10/31/11, indicated an unstageable area to the left foot arch, measuring 1.2 cm by 2.5 cm, which was 100 percent eschar, and pink surrounding skin with swelling. Physician orders, dated 11/1/11, indicated cover the left lateral foot arch with a dry abdominal pad and fix with loose kerlix, change daily and as needed for loosening/soilage. Also a venous doppler study was ordered to the bilateral lower extremities, for swelling and pain to rule out deep vein thrombosis. Another physician order, dated 11/1/11, indicated bilateral extremity compression wraps with lymphatic massage was ordered due to edema. A bilateral lower extremity venous ultrasound test, dated 11/2/11, indicated no evidence of deep vein thrombosis involving the lower extremities bilaterally. A pressure ulcer evaluation, dated 11/7/11, indicated the area was unstageable, 100 percent eschar, and measured 1.1 cm by 3.0 cm. An occupational therapy daily treatment note, dated 11/16/11, indicated resident labs were drawn on 11/15/11, and the			

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	therapist was withholding the compression wraps due to the abnormal lab results. A physical therapy progress report, dated 11/18/11, indicated the open area to the left foot was improving, but now noted a small pressure area laterally to the right foot, and nursing was notified. A narrative nursing note, dated 11/18/11, at 11:15 a.m., indicated a new wound sheet was completed for a small, dry, deep tissue injury to the lateral side of the right foot, measuring 2 cm by 2 cm. A pressure ulcer evaluation form, dated 11/18/11, indicated there was a deep tissue injury to the right foot, lateral side, measuring 2 cm by 2 cm, no odors, no drainage, epithelialization, hard/scarred wound edges, and pink surrounding skin. A pressure ulcer evaluation form, dated 11/21/11, indicated the area on the right foot was unstageable, measured 0.5 by 0.8 cm, no odor or drainage, 100 percent eschar, wound edges defined, and the surrounding skin was pink. A pressure ulcer evaluation, dated 12/12/11, indicated the area was healed to the right foot. On 11/22/11 the resident was transferred			

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	to the hospital for a scheduled blood transfusion. A pressure ulcer evaluation, dated 12/19/11, indicated the area located on the left foot arch measured length was 0.8 centimeters (cm) and 1.8 cm. On 12/20/11 at 12:15 p.m. the LPN Wound Nurse was interviewed in regard to the cause of the pressure ulcers and she indicated she thought the pressure ulcers developed due to the resident had cellulitis and edema. On 12/20/11 at 12:45 p.m. the Certified Occupational Therapy Assistant (COTA) was interviewed in regard to the compression wraps and indicted the resident wore the compression wraps for 23 hours a day 7 days a week. The COTA further indicated she applied the wraps through the week and Nursing applied the wraps on the week-ends and both nursing and COTA were responsible for assessing the residents bilateral legs when the wraps were removed for 1 hour a day. On 12/20/11 at 4:55 p.m. the Director Nursing Service (DNS) was interviewed in regard to the resident's pressure ulcer and she indicated the resident only wore shoes in therapy after the first pressure			

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	ulcer developed. The DNS further indicated the resident had a special pressure reduction mattress with a "heel slope" On 12/21/11 at 10:45 a.m. an observation of the resident's pressure area with RN #3 was obtained to the left foot arch and the wound bed was pink and surrounding tissue were pink and slightly swollen with a scant amount of serosanguineous drainage on the old dressing. This federal tag relates to complaint IN00101272 3.1-40(a)(1) 3.1-40(a)(2)			